FREQUENTLY ASKED QUESTIONS
Intimate Partner Violence in the United States — 2010

The following questions and answers are intended to anticipate interest in "Intimate Partner Violence in the United States—2010," a report based on data from the National Intimate Partner and Sexual Violence Survey (NISVS). These questions may be raised by various constituents—such as media, funders, collaborators, etc.—and possible responses are provided.

The questions are organized by the following categories:

- General Questions
- Background and Methods
- Interpreting NISVS Results
- Implications of the Findings
- Limitations of this Report
- NISVS & Other Surveys

General Questions

Q. What is this report about?

This report examines lifetime and 12-month intimate partner violence (IPV) victimization among male and female adults in the United States. The report also provides information about the context of victimization experiences, such as the frequency, severity, patterns, need for services, and impacts of violence experienced.

Q. What is the most important thing people need to know about this report?

IPV remains a public health issue of significant importance, negatively impacting millions of women and men in the United States each year.

Q. Will CDC issue a report like this every year? There are no plans to release a report every year. However, this information will be released periodically.

Q. Why is this report important?

The findings in this report underscore the heavy toll that IPV places on women and men in the United States. They also confirm that IPV has significant adverse consequences for physical and mental health. Lastly, these data have implications for prevention, suggesting who may be at greatest risk and reflecting the importance of primary prevention efforts that begin at an early age and prevent IPV before it begins.

Q. What are the key findings?

- The burden of IPV is particularly felt by women, racial/ethnic minorities, sexual minorities, those with lower incomes, and those who have experienced recent food and housing insecurity.
- IPV victimization begins early with nearly 70% of female victims and nearly 54% of male victims having experienced IPV prior to age 25, suggesting that primary prevention must begin at an early age.
- Among women and men who experienced IPV during their lifetime, more than 1 in 3 female victims and more than 1 in 7 male victims reported needing at least one type of IPV-related service in response to victimization.
- IPV is associated with negative physical and mental health conditions.

Q. What should people do with this information?

This information can shed light on intimate partner violence victimization experienced by male and female adults in the United States. It will inform programs and policies aimed at implementing effective and appropriate strategies to prevent and respond to those affected by IPV.

Q. How does this compare to the 2010 NISVS Summary Report?

This report provides a more detailed and comprehensive examination of the burden of IPV in the United States relative to *The National Intimate Partner and Sexual Violence Survey (NISVS): 2010 Summary Report* (Black et al., 2011). This report presents findings on the:

- Prevalence of individual IPV behaviors;
- Prevalence of IPV victimization by sociodemographic variables, such as race/ethnicity, sexual orientation, recent food and housing insecurity, and income;
- Characteristics of IPV victimization, including the number of lifetime perpetrators, sex of perpetrator, and age at first IPV victimization;
- Associations between IPV victimization and physical and mental health conditions; and
- Services needed and disclosure related to IPV victimization.

Further, the report compares prevalence among sociodemographic groups (e.g., sex, race/ethnicity, income level) to inform prevention practices by identifying populations at greatest risk of victimization). Finally, because results are based on a sample and not a census of U.S. adults, the report provides numbers describing uncertainty around prevalence estimates (i.e., 95% confidence intervals).

Q. What is the CDC planning to do with this information?

This report documents the public health burden that IPV exerts on a wide range of groups with differing demographic characteristics. Consequently, a community-level approach is needed in order to implement effective prevention and response strategies for those who are affected by IPV.

This information informs CDC's DELTA FOCUS program (Domestic Violence Prevention Enhancement and Leadership Through Alliances, Focusing on Outcomes for Communities United with States), which seeks to prevent IPV at national, state, and local levels through implementing and evaluating IPV prevention strategies.

The findings of this report also reflect that IPV victimization begins at an early age and suggest the need for primary prevention strategies that prevent IPV from occurring in the first place. One of the goals of CDC's Dating Matters initiative—a comprehensive program for youth, their parents, educators, and the neighborhoods in which they live—is to test evidence-based and evidence-informed strategies within high-risk urban communities to help us identify potential primary prevention strategies for groups at high-risk for teen dating violence.

Q. How was the survey funded?

The 2010 data collection was funded by the Centers for Disease Control and Prevention in cooperation with the National Institute of Justice and Department of Defense.

Background and Methods

Q. What was the survey methodology of NISVS?

NISVS is a national random digit dial (RDD) telephone survey of the non-institutionalized English and Spanish-speaking U.S. population aged 18 or older. NISVS uses a dual-frame sampling strategy that includes both landline and cell phones. One in 4 adults in the U.S. now live in a cell phone only household. NISVS makes use of the latest U.S. telephone user and usage information. This dual-frame sampling strategy is used in other RDD telephone surveys conducted by the CDC and by other government agencies. The survey was conducted in all 50 states and the District of Columbia.

Q. What was the overall response rate to the survey of NISVS?

The overall weighted response rate for the 2010 data collection for NISVS ranged from 27.5% to 33.6%, while the weighted cooperation rate was 81.3%. In short, once contact was made and eligibility determined, the majority of respondents chose to participate in the survey.

Interpreting NISVS Results

Q. What does the added detail included in this report contribute to our understanding of IPV?

The primary purpose of this report is to describe the public health burden of IPV in the United States and to provide information about the context of victimization experiences. In response to calls from the field, this report moves beyond a focus upon whether a person has or has not experienced IPV and adds greater context to prevalence estimates. This report also provides a more detailed and comprehensive examination of the burden of IPV, such as the overlap of types of IPV, the number of violent behaviors experienced, the frequency and severity of IPV, and the physical and mental health impact. An improved understanding of the range of experiences associated with IPV victimization is necessary to better inform intervention and prevention approaches.

Q. What does this report say about the need for services as a result of IPV victimization?

The estimated number of men and women who reported that they needed services (medical care, legal services, victim's advocate services, housing, and community services) as result of IPV victimization in their lifetime was more than 20 million. The proportion of female victims reporting that they needed a particular service was significantly higher than the proportion of men who said they needed the same service, but both men and women reported that they did not always receive needed services. Less than 50% of female victims who indicated a need for housing or victim's advocate services during their lifetime reported that they received them. For male victims, nearly 2 out of 3 (65.7%) that needed services during their lifetime did not receive any services. A better understanding of the barriers to service that victims experience could strengthen prevention and responses to IPV.

Q. What does this report say about the disclosure of IPV victimization?

The majority of male and female IPV victims disclosed their victimization to someone, primarily a friend or a family member. The proportion of victims that disclosed to someone was higher among women than men (84.2% and 60.9%, respectively). The percentage of victims who disclosed their victimization to a health professional was low—21.1% of female victims and 5.6% of male victims disclosed their victimization to a doctor or nurse at some point in their lifetime. However, when disclosing to police, psychologists/counselors, friends, and family members, the proportion of men who considered disclosure as being "very helpful" was significantly lower than the proportion of women who considered disclosure as being "very helpful."

Implications of the Findings

Q. What implications do these data have for prevention efforts and services?

This report indicates that IPV victimization begins early with nearly 70% of female victims and nearly 54% of male victims having experienced IPV prior to age 25. This suggests that primary prevention of IPV must begin at an early age. CDC's approach to primary prevention of IPV includes the promotion of healthy relationship behaviors among young people, with the goal of reaching adolescents prior to their first relationships. By influencing relationship behaviors and patterns early through dating violence prevention programs, the goal is to promote healthy relationship behaviors and patterns that can be carried forward into adulthood.

This report identified groups that are at most risk for IPV victimization, such as women, racial/ethnic minorities, sexual minorities, those with lower incomes, and those who have experienced recent food and housing insecurity. These findings suggest the possible need to target prevention resources toward those at greatest risk. While primary prevention programs exist, work needs to be done to determine whether they are effective within specific groups of people, particularly among those identified in this report as being most at risk.

Q. What implications do these data have for future research?

The focus of this report is on describing the public health burden of victimization. In order to better understand how to prevent IPV, CDC also supports research to better understand the causes of IPV perpetration and test prevention strategies. Research examining risk and protective factors is key to understanding how perpetration of violence develops and determining the optimal prevention strategies. While much is known about risks factors at the individual and couple level, there have been few studies examining community and societal-level factors related to perpetration of IPV. Identifying community and societal-level risk factors could be useful in identifying perpetration prevention strategies that have the most potential for broad impact.

Increased attention to protective factors is also critical to developing prevention programs as this knowledge can point to environments or situations that reduce the likelihood of violence perpetration, or prevent the likelihood of perpetration in the first place among those who are at high risk. Finally, additional research is needed to develop and evaluate strategies to effectively prevent the first-time perpetration of IPV and to prevent IPV with specific at-risk groups.

Limitations of this Report

Q. Why weren't you able to address specific questions having to do with age when victimized or types of victimization in specific types of relationships?

We were unable to assess how these findings differ across various categories, including age and relationship type, based on a single year of data. NISVS is an ongoing data collection system. As we are able to combine data across years, we will be able to better describe the interaction of age, and types of IPV victimization.

Q. Why are there so many numbers not reported (for example, numbers for men)?

Estimates that based on 20 or fewer cases were considered unreliable and therefore are not reported. In addition, any estimate that had a relative standard error greater than 30% was also deemed unreliable and not reported. This standard for determining the reliability of estimates is widely used by the CDC.

All samples have a degree of error or uncertainty associated with estimates.

NISVS & Other Surveys

Q. How does NISVS differ from other surveys?

Previous surveys have:

- Primarily been conducted within the context of crime or public safety. For example, the National Crime Victimization Survey (NCVS) collects data on the frequency, characteristics and consequences of criminal victimization. If a person is hit or punched by a spouse or boyfriend or girlfriend, the person may not consider those actions to be crimes or report them as such when asked. NISVS uses a public health context and victims of violence are more likely to disclose their victimization experiences when discussing their health. For example, respondents are first asked about various health conditions to establish a health context for the survey, and then they are asked about victimization experiences using behaviorally-specific questions (e.g., has anyone ever use physical force to make you have vaginal sex).
- Covered only select populations such as school or college populations or people living in particular states [e.g., state-based modules from BRFSS (Behavioral Risk Factor Surveillance System), CHIS (California Health Interview Survey)]. NISVS is a nationally representative sample of English and Spanish-speaking adults in the United States.
- Included a small number of questions. NISVS assesses 60 different violent behaviors.
- Different sampling strategies. For example, NVAWS (National Violence Against Women Survey), ICARIS-2 (Injury Control and Risk of Injury Survey-2), and BRFSS were all telephone surveys, but landline only. NISVS also includes a cell phone sample because one in four adults in the United States now live in a cell phone only household.
- Asked different questions in order to assess the types of violence victimization experienced by respondents. For example the CHIS asked one question regarding physical violence victimization by an intimate partner. NISVS asks a series of behaviorally specific questions to assess multiple forms of IPV victimization.

NISVS is also unique because:

- NISVS is focused exclusively on violence. Surveys that include modules or a few questions on violence and cover other topics in the same survey (e.g., BRFSS, ICARIS-2) typically yield lower prevalence estimates.
- NISVS uses behaviorally-specific questions and avoids the use of questions such as “have you ever been abused?” or “have you ever been raped,” which are subject to interpretation by respondents.
- NISVS is designed to monitor the magnitude and impact of violent victimization and has been designed to be consistent with the way victims recall experiences of violence – all behaviors are linked to a specific perpetrator and all questions are asked within the context of that perpetrator. In this way, NISVS is able to measure the patterns and impacts of the violence.

Q. How is NISVS different from crime data on sexual violence, stalking, and IPV?

NISVS examines sexual violence, stalking, and IPV as public health issues, not as crime issues. To determine how these different contexts affect the reporting of sexual assault, the National Institute of Justice and the Bureau of Justice Statistics conducted the National College Women Sexual Victimization (NCWSV) Study in 2000, comparing the methodologies of the National Crime Victimization Survey

(NCVS) and the National Violence Against Women Survey (NVAWS), which used a health and behavior-based methodology similar to that used in NISVS. The NCWSV study demonstrated that health-based, behaviorally specific questions, like those asked in NISVS, substantially increase disclosure of violence. People may not identify their experiences with sexual violence, stalking, and IPV as crime, especially when it involves someone they know or love.

Q. How do NISVS results compare to those from other surveys?

Given all the differences listed above as well as other methodological differences and differences in timing, it is not appropriate to compare NISVS results to those from other surveys.

For more Frequently Asked Questions on NISVS or the 2010 NISVS Summary Report, please view the Communications Toolkit at www.cdc.gov/violenceprevention/nisvs.